FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015032

Facility Name: Washington and Jane Smith Community

Address: 2340 W. 113th Place (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 779-8010 **Fax #** (773) 779-8648

IDPA ID Number: 362167948001 **License No.** 0015032

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Scott E. Martin, CPA **Telephone Number:** (574) 232-3992

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2004 to 06/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Michael A. Flynn

(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)

(Print Name and Title) Scott E. Martin, CPA

(Firm Name & Address) Crowe Chizek and Company LLC, 330 E. Jefferson Blvd., South Bend, IN 46624

(Telephone) (574) 232-3992 Fax # (574) 236-8692

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	185	67,525	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	101,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,171	18,562	2,533	31,266	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	5,011	33,661		38,672	12
13	DD 16 OR LESS					13
14	TOTALS	15,182	52,223	2,533	69,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.68%

D. How many bed-hold days during this year were paid by the Department?
10 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/25/1926

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,533

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	551,765		14,614	566,379		566,379		566,379			1
2	Food Purchase		791,388		791,388		791,388	(3,317)	788,071			2
3	Housekeeping	266,096	50,336		316,432		316,432		316,432			3
4	Laundry	102,485	21,878		124,363		124,363		124,363			4
5	Heat and Other Utilities			364,373	364,373		364,373		364,373			5
6	Maintenance	294,585	8,136	202,085	504,806		504,806	(36,017)	468,789			6
7	Other (specify):*			26,479	26,479		26,479	(26,479)				7
8	**TOTAL General Services**	1,214,931	871,738	607,551	2,694,220		2,694,220	(65,813)	2,628,407			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,813,455	61,387	69,961	2,944,803	(2,346)	2,942,457	(8,247)	2,934,210			10
10a	Therapy			236,581	236,581	2,346	238,927		238,927			10a
11	Activities	299,376	16,040	24,458	339,874		339,874		339,874			11
12	Social Services			1,443	1,443		1,443		1,443			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			1,319	1,319		1,319	(1,319)				15
16	**TOTAL Health Care and Programs**	3,112,831	77,427	351,762	3,542,020		3,542,020	(9,566)	3,532,454			16
	C. General Administration											
17	Administrative	101,803		1,606,947	1,708,750		1,708,750	(1,606,947)	101,803			17
18	Directors Fees											18
19	Professional Services			58,083	58,083		58,083	(803)	57,281			19
20	Dues, Fees, Subscriptions & Promotions			24,307	24,307		24,307		24,307			20
21	Clerical & General Office Expenses	179,193	36,207	116,498	331,898	(10,337)	321,561	(1,192)	320,369			21
22	Employee Benefits & Payroll Taxes			1,260,689	1,260,689		1,260,689	(3,579)	1,257,110			22
23	Inservice Training & Education			542	542		542		542			23
24	Travel and Seminar			2,803	2,803		2,803		2,803			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			167,647	167,647		167,647		167,647			26
27	Other (specify):*			6,520	6,520		6,520	(6,520)				27
28	**TOTAL General Administration**	280,996	36,207	3,244,036	3,561,239	(10,337)	3,550,902	(1,619,041)	1,931,862			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,608,758	985,372	4,203,349	9,797,479	(10,337)	9,787,142	(1,694,420)	8,092,723			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington and Jane Smith Community #0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			476,927	476,927		476,927	(24,481)	452,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			217,616	217,616		217,616	(16,047)	201,569			32
33	Real Estate Taxes			7,073	7,073		7,073	(7,073)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					10,337	10,337		10,337			35
36	Other (specify):* **Amort debt issuance**			197,769	197,769		197,769	(190,353)	7,416			36
37	**TOTAL Ownership**			899,385	899,385	10,337	909,722	(237,954)	671,768			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		552,845		552,845		552,845		552,845			39
40	Barber and Beauty Shops			43,877	43,877		43,877	(33,906)	9,971			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):*	86,040	381	28,566	114,987		114,987	(114,987)				43
44	**TOTAL Special Cost Centers**	86,040	553,226	123,908	763,174		763,174	(148,893)	614,281			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,694,798	1,538,598	5,226,642	11,460,038		11,460,038	(2,081,267)	9,378,772			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Part V - Cost Center Expenses - Supplemental Schedule for Other Adjustments

Description	Amount	Line
Depreciation expense for R&M capitalized	7,128	30

Part V - Reclassifications

		From Line	To Line
Reclassify speech therapy	2,346	10	10a
Reclassify postage machine & copier lease exp	10,337	19	35

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,317)	2		4
5	Telephone, TV & Radio in Resident Rooms	(809)	21		5
6	Rented Facility Space	(31,017)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,000)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,298)	27		18
19	Entertainment				19
20	Contributions	(1,250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168,433)	36		24
25	Fund Raising, Advertising and Promotional	(86,834)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(183,490)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (481,448)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (481,448)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Washington and Jane Smith Community

ID# 0015032

Report Period Beginning: 07/01/2004

Ending: 06/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cable TV	$ (26,479)	7	1
2	Unallowable x-ray & lab services	(8,247)	10	2
3	Flowers	(1,319)	15	3
4	Marketing consultant	(463)	19	4
5	Misc resident charges	(383)	21	5
6	Misc income - COBRA	(3,579)	22	6
7	Investment advisory fee	(10,222)	27	7
8	Legal settlement	6,250	27	8
9	Depreciation - Apt	(31,609)	30	9
10	Interest exp on gift annuities	(16,050)	32	10
11	Bond interest - Apt	3	32	11
12	Property taxes	(7,073)	33	12
13	Misc. bond expense	(21,920)	36	13
14	Beauty shop revenue	(33,906)	40	14
15	Podiatry	(4,597)	43	15
16	Bldg & Gr Apt - Supplies General	(2)	43	16
17	Bldg & Gr Apt - Yard Maintenance	(1,160)	43	17
18	Bldg & Gr Apt - Rep & Mtce Equipment	(1,343)	43	18
19	Bldg & Gr Apt - Rep & Mtce Paint	(2)	43	19
20	Bldg & Gr Apt - Rep & Mtce Plumbing	(196)	43	20
21	Bldg & Gr Apt - Rep & Mtce Bldg	(2,690)	43	21
22	Repair & Maintenance - Heating	(288)	43	22
23	Interest on Security Deposit	(175)	43	23
24	Bldg & Gr Apt - Refuse Disposal	(1,103)	43	24
25	Heat Power - Apt Utilities Gas	(13,063)	43	25
26	Heat Power - Apt Utilities Electric	(1,948)	43	26
27	Heat Power - Apt Utilities Water	(1,586)	43	27
28	Unallowable legal expense	(340)	19	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(183,490)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington and Jane Smith Community **#** 0015032 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,317)	0	0	0	0	0	0	0	0	0	0	(3,317)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(36,017)	0	0	0	0	0	0	0	0	0	0	(36,017)	6
7	Other (specify):*	(26,479)	0	0	0	0	0	0	0	0	0	0	(26,479)	7
8	**TOTAL General Services**	(65,813)	0	0	0	0	0	0	0	0	0	0	(65,813)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,247)	0	0	0	0	0	0	0	0	0	0	(8,247)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,319)	0	0	0	0	0	0	0	0	0	0	(1,319)	15
16	**TOTAL Health Care and Programs**	(9,566)	0	0	0	0	0	0	0	0	0	0	(9,566)	16
	C. General Administration													
17	Administrative	0	(1,606,947)	0	0	0	0	0	0	0	0	0	(1,606,947)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(803)	0	0	0	0	0	0	0	0	0	0	(803)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,192)	0	0	0	0	0	0	0	0	0	0	(1,192)	21
22	Employee Benefits & Payroll Taxes	(3,579)	0	0	0	0	0	0	0	0	0	0	(3,579)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(6,520)	0	0	0	0	0	0	0	0	0	0	(6,520)	27
28	**TOTAL General Administration**	(12,094)	(1,606,947)	0	0	0	0	0	0	0	0	0	(1,619,041)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,473)	(1,606,947)	0	0	0	0	0	0	0	0	0	(1,694,420)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Washington and Jane Smith Community** **#** **0015032** **Report Period Beginning:** **07/01/2004** **Ending:** **06/30/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,481)	0	0	0	0	0	0	0	0	0	0	(24,481)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,047)	0	0	0	0	0	0	0	0	0	0	(16,047)	32
33	Real Estate Taxes	(7,073)	0	0	0	0	0	0	0	0	0	0	(7,073)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(190,353)	0	0	0	0	0	0	0	0	0	0	(190,353)	36
37	**TOTAL Ownership**	(237,954)	0	0	0	0	0	0	0	0	0	0	(237,954)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(33,906)	0	0	0	0	0	0	0	0	0	0	(33,906)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(114,987)	0	0	0	0	0	0	0	0	0	0	(114,987)	43
44	**TOTAL Special Cost Centers**	(148,893)	0	0	0	0	0	0	0	0	0	0	(148,893)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(474,320)	(1,606,947)	0	0	0	0	0	0	0	0	0	(2,081,267)	45

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Services	$ 1,606,947	Washington and Jane Smith Home (Corporate)	0.00%	$	$ (1,606,947)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,606,947			$	$ * (1,606,947)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James J. Nemec	Board Member	Trustee of the	None	None	5	12.50	Financial	$ 10,222	27-03	1
2			Board and Owner					Services			2
3			of Heritage Capital								3
4											4
5	Allen K. Flagler	Board Member	Trustee of the	None	None	0	0.00	Insurance	167,647	26-03	5
6			Board and Owner					Premiums			6
7			of Orthon Group								7
8											8
9	Thomas E. Chomicz	Board Member	Trustee of the	None	None	Less than 1	0.00	Legal Svc	2,154	19-03	9
10			Board and Partner								10
11			at Quarles & Brady								11
12											12
13								TOTAL	$ 180,023		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		x	Construction	Varies	1991	$ 5,800,000	$ 5,800,000	7/1/2026	Variable	$ 201,569	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,800,000	$ 5,800,000			$ 201,569	9
	B. Non-Facility Related*											
10	Bond Interest - Apt										(3)	10
11	Interest on Gift Annuities										16,050	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 16,047	14
15	TOTALS (line 9+line14)						$ 5,800,000	$ 5,800,000			$ 217,616	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ n/a Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Washington and Jane Smith Community **#** 0015032 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002		10
2003		11
2004		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington and Jane Smith Community COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT Scott E. Martin, CPA

TELEPHONE (574) 232-3992 FAX #: (574) 236-8692

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,004 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

11248 S. Oakley Avenue - Morrison Home (CIP only in c/y)

11365 S. Western Avenue - Apartments (costs adjusted out on page 5)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	247,516	Pre 1994	$ 649,404	1
2					2
3	TOTALS	247,516		$ 649,404	3

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1924		$ 70,920	$		$	$	$ 70,920	4
5	57			1928	438,552					438,558	5
6	55			1958	429,080					429,080	6
7	50			1972	1,528,440	43,670	35	43,670		1,187,028	7
8	77			1992	4,868,578	139,102	35	139,102		1,808,328	8
	Improvement Type**										
9	Various			1974	48,223		20			48,223	9
10	Various			1980	102,046		20			102,046	10
11	Various			1981	31,819		20			31,819	11
12	Various			1982	53,600		20			53,600	12
13	Various			1983	163,759		20			163,759	13
14	Various			1984	190,740		20			190,740	14
15	Various			1985	26,309	1,315	20	1,315		26,307	15
16	Various			1987	149,405		20			149,405	16
17	Various			1989	232,022	9,004	20	9,004		228,227	17
18	Various			1991	1,091,229	26,604	20	26,604		519,270	18
19	Various			1993	109,928	6,582	20	6,582		85,196	19
20	Various			1994	102,711		20			102,711	20
21	Various			1995	270,529	10,482	20	10,482		144,353	21
22	Various			1996	42,902	2,366	20	2,366		23,400	22
23	Various			1997	374,149	33,011	20	33,011		276,133	23
24	Various			1998	293,792	20,034	20	20,034		142,369	24
25	Various			1999	215,142	16,833	20	16,833		100,511	25
26	Various			2000	93,242	6,057	20	6,057		35,319	26
27	Various			2001	110,553	9,967	Various	9,967		46,223	27
28	R&M Capitalized			2001	30,970		Various	2,152	2,152	10,772	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,068,640	$ 325,027		$ 327,179	$ 2,152	$ 6,414,297	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,068,640	$ 325,027		$ 327,179	$ 2,152	$ 6,414,297	1
2	Paint	2002	2,090	105	20	105		418	2
3	Air conditioner	2002	298	30	10	30		119	3
4	Water heater	2002	4,026	403	10	403		1,610	4
5	Storm damage repair - Roof & Gutters	2002	28,675	1,147	25	1,147		4,588	5
6	115 V pump	2002	1,009	101	10	101		404	6
7	Landscape	2002	2,310	116	20	116		462	7
8	Upgrade fire system	2002	1,645	82	20	82		329	8
9	Painting	2002	12,635	1,263	10	1,263		5,054	9
10	Upgrade kitchen wiring for dishwasher	2002	7,850	393	20	393		1,570	10
11	Paint & Wall removal	2002	9,460	946	10	946		3,784	11
12	Paint	2002	809	81	10	81		324	12
13	Generator fuel tank & pump	2002	1,500	75	20	75		300	13
14	Refurbish Oakley booster pump	2002	1,401	140	10	140		560	14
15	Paint stairwells	2002	982	98	10	98		393	15
16	Painting - R&M	2002	3,150		20	158	158	632	16
17	Sewage Pump R&M	2002	720		20	36	36	144	17
18	Flag pole R&M	2002	644		20	32	32	129	18
19	Valves & Operator R&M	2002	1,299		10	130	130	520	19
20	Morrison exhaust fan	2002	899	90	10	90		270	20
21	Front door replacement	2002	1,600	160	10	160		480	21
22	Boiler repairs	2002	1,625	162	10	162		487	22
23	Painting	2002	1,275	128	10	128		383	23
24	Morrison sidewalks	2002	4,795	480	10	480		1,439	24
25	Painting	2002	595	60	10	60		179	25
26	Painting	2002	1,360	136	10	136		408	26
27	Painting	2002	1,050	105	10	105		315	27
28	Drapes	2002	256	26	10	26		77	28
29	Paint & Supplies R&M	2002	513		10	51	51	204	29
30	Paint & Supplies R&M	2002	746		10	75	75	300	30
31	Repair Aurora pump R&M	2002	814		10	81	81	324	31
32	Heavy duty door R&M	2002	2,009		10	201	201	804	32
33	Repair gate R&M	2002	500		10	50	50	200	33
34	TOTAL (lines 1 thru 33)		$ 11,167,180	$ 331,354		$ 334,320	$ 2,966	$ 6,441,507	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,167,180	$ 331,354		$ 334,320	$ 2,966	$ 6,441,507	1
2	Resident room carpeting R&M	2002	1,510		10	151	151	604	2
3	Door locks R&M	2002	528		10	53	53	212	3
4	Pump repair R&M	2002	847		10	85	85	340	4
5	Boiler repair R&M	2002	675		10	68	68	272	5
6	Repair dairy walk-in cooler R&M	2002	1,474		10	147	147	588	6
7	Boiler repair	2003	5,396	540	10	540		1,619	7
8	Fire alarm panel repair	2003	1,947	195	10	195		584	8
9	Painting	2003	3,574	357	10	357		1,072	9
10	Turn-on lawn sprinkler R&M	2003	896		10	90	90	270	10
11	Turn-on lawn sprinkler R&M	2003	770		10	77	77	231	11
12	Paint & Supplies R&M	2003	1,273		10	127	127	381	12
13	Resident room carpeting R&M	2003	798		10	80	80	240	13
14	Resident room carpeting R&M	2003	506		10	51	51	153	14
15	Resident room carpeting R&M	2003	644		10	64	64	192	15
16	Resident room carpeting R&M	2003	1,257		10	126	126	378	16
17	Replace compressor R&M	2003	1,180		10	118	118	356	17
18	Repair air conditioning R&M	2003	1,769		10	177	177	431	18
19	Repair delfield cooler R&M	2003	1,163		10	116	116	348	19
20	Replace fill valve & drain asse R&M	2003	623		10	62	62	186	20
21	Drapes	2003	2,296	230	10	230		689	21
22	Painting North Entrance	2003	1,880	188	10	188		564	22
23	Painting reception area	2003	1,975	198	10	198		593	23
24	Door security - Patio off main sitting room	2003	6,694	669	10	669		2,008	24
25	Chimney Work	2003	2,720	272	10	272		816	25
26	Tuckpointing - North Courtyard vent	2003	1,380	138	10	138		414	26
27	Auditorium Fire Door	2003	1,205	60	20	60		115	27
28	Booster Pump Repair	2003	3,933	393	10	393		754	28
29	Johansen Windows	2003	2,652	133	20	133		243	29
30	Smith NE Flat Roof	2003	8,720	2,907	3	2,907		5,329	30
31	Johansen Roof Coating	2003	7,900	790	10	790		1,448	31
32	Window Treatments	2003	1,040	208	5	208		364	32
33	Tub & Toilet Floors - Johansen	2003	12,900	1,290	10	1,290		2,258	33
34	TOTAL (lines 1 thru 33)		$ 11,249,305	$ 339,922		$ 344,480	$ 4,558	$ 6,465,559	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,249,305	$ 339,922		$ 344,480	$ 4,558	$ 6,465,559	1
2	Painting Johansen	2003	15,977	3,195	5	3,195		5,592	2
3	Painting Johansen	2003	4,093	819	5	819		1,364	3
4	Painting Johansen	2004	2,340	468	5	468		663	4
5	Painting Johansen	2004	7,896	1,579	5	1,579		1,711	5
6	Compartment Sinks	2004	1,291	129	10	129		194	6
7	Electrical conduit & wiring	2004	1,957	196	10	196		212	7
8									8
9	Water drain	2005	900	45	20	45		45	9
10	Vinyl flooring - bathrooms	2005	4,960	496	10	496		496	10
11	Electrical wiring	2005	5,355	268	20	268		268	11
12	Parking lot pavement	2005	7,100	740	8	740		740	12
13	Mini-blinds Johansen	2005	3,000	450	5	450		450	13
14	Painting kitchen ceiling	2005	4,044	607	5	607		607	14
15	Mini-blinds Johansen	2005	4,017	536	5	536		536	15
16	Electrical wiring	2005	3,334	111	20	111		111	16
17	Painting lobby & auditorium	2005	1,950	228	5	228		228	17
18	Vinyl flooring	2005	26,260	1,532	10	1,532		1,532	18
19	Sewer line	2005	9,290	232	20	232		232	19
20	Surveillance Camera	2005	1,864	186	5	186		186	20
21	Painting Johansen	2005	7,475	249	5	249		249	21
22	Painting Johansen	2005	4,300	143	5	143		143	22
23	Painting common areas	2005	3,302	55	5	55		55	23
24	Wheelchair/armrest - R&M	2005	725		5	145	145	145	24
25	Kitchen equipment - R&M	2005	16,975		7	2,425	2,425	2,425	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,387,710	$ 352,186		$ 359,314	$ 7,128	$ 6,483,743	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 634,177	$ 83,629	$ 83,629	$	Various	$ 336,909	71
72	Current Year Purchases	202,546	3,862	3,862		Various	3,862	72
73	Fully Depreciated Assets	864,283				Various	864,283	73
74								74
75	TOTALS	$ 1,701,006	$ 87,491	$ 87,491	$		$ 1,205,054	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility	2000 Ford Goshen Bus	2000	$ 45,104	$ 3,007	$ 3,007	$	15	$ 15,035	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,190	2,190		10	6,571	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	444	444		10	444	78
79										79
80	TOTALS			$ 84,765	$ 5,641	$ 5,641	$		$ 22,050	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,822,885	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 445,318	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 452,445	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,128	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,710,847	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Apt	$ 112,500	$	$	86
87	Building Apt	487,975	12,199	103,695	87
88	Building Improv. Apt	187,351	16,219	81,664	88
89	Furniture Apt	31,841	1,213	29,722	89
90	Morrison Home/Oakley St	440,692	1,978		90
91	TOTALS	$ 1,260,359	$ 31,609	$ 215,081	91

G. Construction-in-Progress

	Description	Cost	
92	Morrison Home	$ 8,270,151	92
93			93
94			94
95		$ 8,270,151	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 10,337 Description: Copiers - $9,514; Postage Meter - $823
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	$	1,554	$ 75,741	$	1,554	$ 75,741	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		149	9,384		149	9,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		4,381	150,527		4,381	150,527	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	6,084	$ 235,652	$	6,084	$ 235,652	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Washington and Jane Smith Community # 0015032 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 332,181	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 445,119)	446,873		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,879		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached	1,437,115		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,289,048	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,339,125		12
13	Land	1,202,596		13
14	Buildings, at Historical Cost	11,988,058		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,817,612		16
17	Accumulated Depreciation (book methods)	(7,904,148)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached	9,279,766		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 22,723,009	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 25,012,057	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,115,571	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,440,056		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	8,792,196		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,347,823	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,000,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Gift annuities, net of current	10,521		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,010,521	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,358,344	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,653,713	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 25,012,057	$	48

***(See instructions.)**

Facility Name & ID Number: Washington and Jane Smith # 0015032 Report Period Beginning: 07/01/04 Ending: 06/30/05

Supplemental Schedule of Other Assets and Liabilities As of 6/30/05

	Other Current Assets:	Amount
09A	LaSalle deposit escrow	1,436,815
09B	Other receivables - employees	300
09C		
09D		
09E		
09F		
09G		
		1,437,115

	Other current Liabilities:	Amount
36A	Accrued compensation	456,831
36B	Accrued pension	195,084
36C	Resident credit balances	88,449
36D	Advance from affiliate	7,224,453
36E	Other	11,929
36F	Gift Annuities payable	15,450
36G	Current portion of long-term debt	800,000
		8,792,196

	Other Non-Current Assets:	Amount
23A	Cost of acquiring initial continuing care contracts	853,884
23B	Construction in Progress	8,270,151
23C	Net debt issuance cost	155,731
23D		
23E		
23F		
23G		
		9,279,766

	Other Non-Current Liabilities:	Amount
23A		
23B		
23C		
23D		
23E		
23F		
23G		
		-

Facility Name & ID Number Washington and Jane Smith Community # 0015032 **Report Period Beginning:** 07/01/2004 **Ending:** 06/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,225,057	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,225,057	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,571,344)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,571,344)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,653,713	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,012,663	1
2	Discounts and Allowances for all Levels	(1,190,258)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,822,405	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	551,274	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 551,274	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	33,906	13
14	Non-Patient Meals	3,317	14
15	Telephone, Television and Radio	809	15
16	Rental of Facility Space	28,000	16
17	Sale of Drugs	530,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29	19
20	Radiology and X-Ray		20
21	Other Medical Services	329,913	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 926,489	23
	D. Non-Operating Revenue		
24	Contributions	(207,858)	24
25	Interest and Other Investment Income***	883,024	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 675,166	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	(86,640)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (86,640)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,888,694	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,694,220	31
32	Health Care	3,542,020	32
33	General Administration	3,561,239	33
	B. Capital Expense		
34	Ownership	899,385	34
	C. Ancillary Expense		
35	Special Cost Centers	711,709	35
36	Provider Participation Fee	51,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,460,038	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,571,344)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,571,344)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

XVII. INCOME STATEMENT - Detail of Other Revenue, Line 28

Description	Amount
Apartment Rents	$ 133,097
Resident Transport	5,000
Miscellaneous Resident Charges	383
Guest Room Income	3,017
Other Miscellaneous	13,146
Gain/(Loss) on disposal of fixed assets	(201,283)
Lease settlement	(40,000)
	$ (86,640)

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,770	1,863	$ 68,109	$ 36.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,411	20,117	417,521	20.75	3
4	Licensed Practical Nurses	36,948	37,831	534,236	14.12	4
5	CNAs & Orderlies	114,898	125,552	1,481,205	11.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,646	2,750	53,171	19.33	8
9	Activity Director	1,883	1,863	34,504	18.52	9
10	Activity Assistants	21,967	22,991	252,072	10.96	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	48,468	51,349	523,312	10.19	15
16	Dishwashers					16
17	Maintenance Workers	12,554	13,524	278,042	20.56	17
18	Housekeepers	26,646	28,172	274,667	9.75	18
19	Laundry	8,679	9,652	99,114	10.27	19
20	Administrator	1,950	1,863	98,684	52.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,954	23,418	378,084	16.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,649	1,911	27,134	14.20	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	6,337	6,482	174,943	26.99	33
34	TOTAL (lines 1 - 33)	328,760	349,338	$ 4,694,798 *	$ 13.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	3,832	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,016	10-03	39
40	Physical Therapy Consultant	26	1,437	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,080	11-03	44
45	Social Service Consultant	26	1,443	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	92	$ 34,808		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,055	$ 16,327	10-03	50
51	Licensed Practical Nurses	3,054	23,617	10-03	51
52	Certified Nurse Assistants/Aides	42	158	10-03	52
53	TOTAL (lines 50 - 52)	5,151	$ 40,102		53

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Philip Hemmer	Exec Director	0	$ 101,803
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,803

B. Administrative - Other

Description	Amount
Management services	$ 1,606,947
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,606,947
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Crowe Chizek/Frost, Ruttenberg	Acctg Svc	$ 21,850
Foote, Meyers, Mielke & Flowers	Legal Svc	360
Michael Best & Friedrich, LLP	Legal Svc	176
Quarles & Brady	Legal Svc	2,154
American Heritage Protective	Security consutling	3,960
Bobbye Cochran & Associates	Graphics design	2,158
Ameripay	Payroll Svc	11,373
Health Resources Alliance	Consulting	1,500
Icomm Consulting	Telephone consulting	1,503
Long Term Care Associates, Ltd	LTC issues consulting	6,900
Service Trac, LLC	Resident/employee survey	5,686
Sheila King	Marketing consultant	463
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 58,083

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 135,115
Unemployment Compensation Insurance	2,518
FICA Taxes	346,102
Employee Health Insurance	399,553
Employee Meals	59,768
Illinois Municipal Retirement Fund (IMRF)*	
Tuition reimbursement	2,265
Employee appreciation special events	12,195
Employee recognition	11,928
Disability insurance	5,143
Life insurance	4,301
Pension expense	278,222
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,257,110

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,252
Health Care Worker Background Check	
(Indicate # of checks performed)	
Other taxes and fees	2,055
Dues & subscriptions	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,407

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7
Seminar Expense	2,796
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,803

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,398** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **51,465**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **59,768** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Crowe Chizek and Company LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees